FINALIZED SEER SINQ'S

MAY 2012

Question: 20120039

Status
Final

Question
Primary site/Heme & Lymphoid Neoplasms: What site do I code this to and what rule applies? How did you arrive at this? Please advise. See discussion.

Discussion
Patient with history of Chronic Lymphocytic Leukemia (CLL). 02/2011 Abdomen/Pelvis xray showed development of bilateral renal masses. 04/04/11 PET scan showed intense areas of hypermetabolic activity corresponding to known bilateral renal masses, new hypermetabolic liver lesions, as well as left upper retroperitoneal lymphadenopathy. All findings worrisome for malignancy. 03/2011 right kidney mass biopsy - positive for Diffuse Large B-cell Lymphoma (DLBCL). Bone marrow biopsy is negative for lymphoma.

Answer
When you have a previous neoplasm, Chronic Lymphocytic Leukemia, and the patient is diagnosed with a different neoplasm, Diffuse Large B-cell Lymphoma, always follow these steps:

1. Look up the previous neoplasm Chronic Lymphocytic Leukemia in the Hematopoietic Database.

2. Check the transformation box. The transformation box shows that Chronic Lymphocytic Leukemia (chronic neoplasm) transforms to Diffuse Large B-cell Lymphoma (acute neoplasm).

3. Look for the M rule that fits the case. For this case, use M10: Abstract a second primary Diffuse Large B-cell Lymphoma when an acute disease occurs more than 21 days after the chronic phase.

Use Module 7 to determine which site to code for lymphomas (DLBCL). PH35 says to code the primary site to the organ (kidneys, bilateral) when the organ and it's regional LN are involved.

History

Last Updated
05/11/12

Question: 20120038

Status
Final

Question
Histology/Heme & Lymphoid Neoplasms: Is there a relevant term to code this case?

A diagnostic report indicates Monoclonal B Lymphocytosis of Uncertain Significance (MLUS), not Monoclonal Gammopathy of Undetermined Significance (MGUS). This term is not referenced in ICDO or SEER Heme database.

Discussion

Answer
This case is not reportable. Some papers point out that lymphocyte count less than 5K = Monoclonal B Lymphocytosis of Uncertain Significance (MLUS) or Monoclonal B-cell Lymphocytosis (MBL). A lymphocyte count 5-30K could be smoldering Chronic Lymphocytic Leukemia (CLL). The diagnosis of MLUS is one of a benign process that does not meet the criteria for CLL.

History

Last Updated
05/11/12

Question: 20120037

Status
Final

Question
Primary site/Heme & Lymphoid Neoplasm: What is the topography code for Primary Effusion Lymphoma? Patient had pleural and pericardial effusion and pleural fluid was positive for Lymphoma.

Discussion

Answer
Code pleura C384. See the Heme DB Abstractor Notes for primary effusion lymphoma 9678/3. There is no ICD-O-3 code for the pleural cavity, which is the actual primary site. The default primary site code is pleura.

History

Last Updated
05/11/12

Question: 20120036

Status
Final

Question
Primary site/Heme & Lymphoid Neoplasms: Would the primary site be coded to C809 or C779?

Patient with known mantle cell lymphoma in history on path report. Bone marrow biopsy read at my facility without involvement of bone marrow. There is no information concerning where lymphoma originated.

Discussion

Answer
Code primary site lymph nodes, NOS C779. See the Hematopoietic Manual, Module 6: Primary Site Rules for Lymphomas PH30. Code the primary site to LN regions, NOS when multiple lymph node regions are involved and it is not possible to identify the lymph node region where the lymphoma originated.

See PH37. The only time unknown primary site C809 is used is when there is no evidence of lymphoma in lymph nodes AND the physician documents that the lymphoma originates in an organ(s).

History

Last Updated
05/11/12

Question: 20120034

Status
Final

Question
Primary site--Brain and CNS: What is the correct site/subsite code? MRI states: left cerebellar venous angioma. According to the WHO Classification of brain/cns tumors, code 9122/0 does not appear under tumors of the cerebellum (C71.6)

Discussion

Answer
This is a venous abnormality. Even though there is an ICD-O-3 code, the primary site would be blood vessel. Therefore it is not reportable. Previously called venous angiomas, these are now referred to as developmental venous anomalies (DVA).

History

Last Updated
05/11/12

Question: 20120018

Status
Final

Question
Histology--Breast: How is histology coded if a lumpectomy reveals multifocal DCIS spanning an area of 0.9-1.2 cm with close margins and a subsequent mastectomy reveals only a single focus of LCIS measuring 0.2 cm in the UOQ, remote from all surgical margins? See discussion.

Discussion
Should we apply the general instruction that states the histology from the most representative tumor specimen be coded, which in this case would be 8500/2 [DCIS]? Or should histology be coded to 8522/2 per MP/H rule H28 [Code 8522 (duct and lobular) when there is any combination of lobular (8520) and duct carcinoma]?

Answer
Use MP/H rule H28 and code 8522 (duct and lobular).

The DCIS and LCIS are separate tumors. The DCIS was removed by the lumpectomy and the LCIS by the mastectomy.

The most representative specimen for the DCIS is the lumpectomy. The most representative specimen for the LCIS is the mastectomy. Both pathology reports must be used in this case.

History

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05/11/12

Question: 20120010

Status
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Question
Multiple primaries/Behavior--Ovary: Is this one or two primaries? If one primary, what is the date of diagnosis and histology?

Patient was diagnosed with an ovarian mucinous borderline tumor in 2003. Now presents with bone metastses. See discussion.

Discussion
2011 PATHOLOGY REPORT:

Spine at L3 biopsy: metastatic adenocarcinoma. Per addendum: prior total abdominal hysterectomy specimen from 2003 was reviewed and showed an ovarian mucinous cystic tumor of borderline malig which has a similar morphology to the invasive adenocarcinoma seen on current specimen.

2011 Pathology report, continued: Abdominal tissue and omental biopsy: invasive and non-invasive glandular implants compatible with origin from ovarian mucinous borderline tumor.

Final diagnosis per radiation oncologist MD, "recurrent ovarian cancer."

Answer

Report this as a 2003 case. Code the behavior as invasive, /3.

This is a case where an invasive or microinvasive element was missed in the original pathology. Since the entire tumor is not sectioned and placed on slides, the pathologist uses their expertise when sectioning and selecting tissue to be examined. It is not a matter of poor judgement, just a fact that it is impossible to review the tissue from the entire tumor.

History

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05/01/12